MATHEW SCOTT OAKLEY & ORS A

v.

DR GEORGE VARUGHESE & ANOR

HIGH COURT MALAYA, KUALA LUMPUR B
HARMINDAR SINGH DHALIWAL JC
[CIVIL SUIT NO: S4-22-200-2006]
29 DECEMBER 2009

CIVIL PROCEDURE: *Adjournment - Application for - Principles - Whether grant of adjournment would prejudice defendants - Defendants will be put to great difficulty and expense to recall their witnesses - Adjournment disallowed* C

TORT: *Negligence - Medical negligence - Burden of proof - Allegation of medical negligence causing death - Doctor who conducted post-mortem and prepared post mortem report not called to give evidence - No independent expert medical opinion provided by plaintiffs - Cause of death as stated in post-mortem report could not be right - Failure to prove negligence* D

TORT: *Negligence - Medical negligence - Skilled medical practitioner - Standard of care - Whether a matter of medical judgment - Whether must accord with standard of reasonableness imposed by law - Test established in Bolitho v. City and Hackney Health Authority - Whether same test applicable in all areas of medical negligence* E

TORT: *Negligence - Professional negligence - Medical Negligence - Standard of care - Whether a matter of medical judgment - Whether must accord with standard of reasonableness imposed by law - Test established in Bolitho v. City and Hackney Health Authority - Whether same test applicable in all areas of medical negligence* F

TORT: *Negligence - Res ipsa loquitor - Application of this principle in relation to medical negligence - Only applicable in very few instances* G

Nik Rosemawati ("the deceased") underwent an abdominal liposuction procedure at a plastic surgery clinic. Minutes after the procedure was completed, she suffered a cardiac arrest. She was then transferred to Gleneagles Intan Medical Centre (GIMC). Two days later she died. She was 44 years old. The 1st plaintiff was the husband and the 2nd and 3rd plaintiffs the children of the deceased. They brought this claim as dependants of the deceased within the meaning of s. 7 of the Civil Law Act 1956 claiming for loss of support. They alleged negligence on the part of the defendants while treating the deceased during the liposuction procedure. The H I

A 1st defendant was the consultant plastic surgeon and the 2nd defendant was the consultant anaesthetist. The defendants denied any negligence on their part. A post-mortem was conducted on the deceased by one Dr Hamidah, a forensic pathologist attached to the Forensic Department of Hospital Kuala Lumpur. She prepared a
B post-mortem report stating that 100 mis of fluid blood was found in the abdominal cavity of the deceased and that the deceased's liver showed linear imprint abrasions with a subcapsular haematoma of 1 cm in diameter. Dr. Hamidah stated the cause of death to be "Acute intraabdominal injury (Perioperative death)". The plaintiffs
C contended that the deceased would not have died if she had not undergone the liposuction procedure and therefore her death must be due to the negligence in her management. After the close of the plaintiffs' case, the plaintiffs applied to reopen their case by calling Dr Mohandas, a consultant anaesthetist at GIMC. The reason given was that there was some suggestion by the witnesses for the
D defendants that the deceased may have been mismanaged at GIMC and the plaintiffs wanted to rebut those allegations. However, Dr. Mohandas was not able to attend court as he had to attend to surgeries scheduled for the day. This prompted learned counsel for the plaintiffs to apply for an adjournment.

E

Held (dismissing the plaintiffs' claim with costs):

(1) The test of standard of care should be a matter of legal judgment as opposed to medical judgment. The analysis of care and skill of medical practitioners should be no different to that
F employed in judging the acts of other professionals. An objective assessment of the standard of care is necessary so as to evaluate and monitor such professional standards. The correct approach is that stated in *Bolitho* (administratix of the estate of *Bolitho (deceased) v. City and Hackney Health Authority* in cases of
G diagnosis and treatment. The same test would apply in all areas of medical negligence. (para 26)

(2) The plaintiffs relied entirely on the post-mortem report. However, Dr Hamidah, who conducted the post-mortem and prepared the report was never called to give evidence. Therefore,
H there was no independent expert medical opinion provided by the plaintiffs. Since the onus to prove causation was on the plaintiffs, expert medical opinion would have been vital to prove that it was the defendant's negligence that caused the demise of the deceased. (para 29)

I

(3) The medical experts were of the view that neither the amount of blood loss in the abdominal cavity nor the injuries reported could have caused death or likely to have caused a cardiac arrest. Based on the evidence, the cause of death as stated in the post-mortem report could not be right. Therefore the plaintiffs failed to prove any negligence on the part of the defendants. (paras 31, 32, 33, 34 & 35)

(4) The cardiac arrest could be from a reaction to the anesthetic drugs used. To suffer an anaphylactic shock from these drugs was a rare condition. So the giving of these drugs could not have been negligent in any way. (paras 41 & 42)

(5) The reopening of the plaintiffs' case was allowed as the cause of death of the deceased was the pivotal issue to be decided at the end of the trial. However, the plaintiffs' application for an adjournment was refused because the reopening of the case was allowed on the understanding that the witness was willing and able to come on the trial dates fixed even without a subpoena. An adjournment would have prejudiced the defendants as they had obtained the services of their experts with great difficulty. It would also prejudice the defendants as they would be put to great difficulty and expense to recall their own witnesses. (paras 53 & 54)

(6) In the field of medicine, there are very few instances where the doctrine of *res ipsa loquitur* may apply. There are far too many variables and medical treatment is not quite a precise science. Even if the injuries were caused by the 1st defendant, it did not necessarily follow that he was negligent. The same applied with the 2nd defendant. There could certainly be other causes beyond their control. Therefore *res ipsa loquitur* did not apply. (para 60)

Case(s) referred to:

Barnet v. Chelsea & Kensington Hospital Management Committee [1968] 1 All ER 1068 ***(refd)***

Bolitho (Administratix Of The Estate Of Bolitho (Deceased) v. City and Hackney Health Authority [1997] 4 All ER 771 ***(refd)***

Chien Tham Kong v. Excellent Strategy Sdn Bhd & Ors [2008] 1 LNS 411 HC ***(refd)***

Elizabeth Choo v. Government of Malaysia & Anor [1960] 1 LNS 24 HC ***(refd)***

Foo Fio Na v. Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(refd)***

Foong Yeen Keng v. Assunta Hospital (M) Sdn Bhd & Anor [2006] 1 CLJ 608 HC ***(refd)***

Girard v. Royal Columbian Hospital et al 66 DLR (3d) 676 ***(refd)***
Hong Chuan Lay v. Dr Eddie Soo Fook Mun [1998] 5 CLJ 251 HC ***(refd)***
Lloyde v. West Midlands Gas Board [1971] 2 All ER 1240 ***(refd)***
Mahon v. Osborne [1939] 2 KB 14 ***(refd)***
Naxakis v. Western General Hospital & Another [1999] 162 ALR 540 ***(refd)***
Ong Yoke Eng & Anor v. Lim Ah Yew [1981] 1 LNS 162 ***(refd)***
Payremalu Veerappan v. Dr Amarjeet Kaur & Ors [2001] 4 CLJ 380 HC ***(refd)***
Roe v. Minister of Health [1954] 2 QB 66 ***(refd)***
Rogers v. Whitaker [1992] 175 CLR 479 ***(refd)***
Scoft v. London & St Katharine Docks Co [1865] 3 H & C 596 ***(refd)***
Tan Kah Khiam v. Liew Chin Chuan & Anor [2006] 4 CLJ 715 CA ***(refd)***
TD Canada Trust v. McMaster et al [2003] BCD (Civ) 16394 ***(refd)***
Wilsher v. Essex Area Health Authority [1988] 1 All ER 871 ***(refd)***

Legislation referred to:
Civil Law Act 1956, s. 7

For the plaintiffs - Renu Zechariah; M/s Rosley Zechariah
For the 1st defendant - Darryl SC Goon (Maidzuara Mohammed with him); M/s Raja, Darryl & Loh
For the 2nd defendant - Suria Kumar; M/s Suria Kumar & Co

Reported by Amutha Suppayah

JUDGMENT

Harmindar Singh Dhaliwal JC:

[1] Nik Rosemawati binti Nik Mohamed ("the deceased") was unhappy with her appearance. She went for an abdominal liposuction procedure at a plastic surgery clinic. Minutes after the procedure was completed, she suffered a cardiac arrest. She was then transferred to Gleneagles Intan Medical Centre. Two days later she died. She was 44 years old.

[2] The 1st plaintiff was the husband and the 2nd and 3rd plaintiffs the children of the deceased. They have filed this claim as dependants of the deceased within the meaning of s. 7 of the Civil Law Act 1956. They are claiming for loss of support. They are alleging negligence on the part of the defendants while treating the deceased during the liposuction procedure. The 1st defendant is a consultant plastic surgeon who, at the material time, practiced as such at the Springvale Plastic Surgery Clinic ("Springvale Clinic") and at Gleneagles Intan Medical Centre ("GIMC"). The 2nd defendant is a consultant anaesthetist. They deny any negligence on their part.

The Facts

[3] From the evidence adduced at the trial, the following facts emerged. The deceased had her first consultation with the 1st defendant in his clinic at GIMC on 16 July 2003. She had wanted to improve the shape of her abdomen. She was advised to have full abdominoplasty with liposuction. She was advised of the procedure and the associated risks. She and her husband, the 1st plaintiff, were also advised to seek a second opinion.

[4] The deceased had a second consultation with the 1st defendant on 5 April 2004. Her options were reviewed. She opted for an abdominal liposuction instead of an abdominoplasty. On 19 June 2004, the deceased was assessed by the 2nd defendant. She signed a form which indicated that she was aware of the risks and consented to local anaesthesia, general anaesthesia or sedation as may be required. She was also reviewed by the 1st defendant. Abdominal liposuction was then scheduled for 21 June 2004 in the afternoon. The procedure was to take place at the 1st defendant's Springvale Clinic which was located at the 1st floor of a shop-lot premise at 23-1, Jalan Telawi Dua, Bangsar Baru, Kuala Lumpur.

[5] On 21 June 2004, the deceased along with the 1st plaintiff went to the Springvale Clinic. They arrived at the clinic at 2.15pm. The deceased's blood pressure was high and medication was given to control the same. At about 3pm, the defendants decided to proceed as the blood pressure was under control.

[6] The abdominal liposuction was to be carried out in two parts - the first was at the lower abdomen and the second was at the upper abdomen. Before the procedure began, sedation was given to the deceased by the 2nd defendant via intravenous injection. This was followed by a local anaesthetic given by the 1st defendant by way of a drip through an infiltration cannula that had been introduced into the lower abdomen. Liposuction of the deceased's lower abdomen was carried out successfully with about 200 mls of fat extracted.

[7] The 1st defendant then proceeded to prepare the deceased's upper abdomen with local anaesthetic. However, infiltration of anaesthetic proved difficult as the deceased appeared uncomfortable and was moving. Despite multiple attempts the 1st defendant could not infiltrate the upper abdomen with local anaesthetic by means of the infiltration cannula. A decision was then made to convert to general anaesthesia. After general anaesthesia, the liposuction of her upper abdomen was carried out uneventfully.

[8] After the procedure was completed, the entry points of the infiltration cannula were sutured and dressed and a pressure garment was applied. This pressure garment was a means of applying direct pressure to stop bleeding and to assist in healing by binding the skin to the abdominal wall.

[9] As far as the 1st defendant could discern, the operation went well and he went out of the operation theatre to inform the 1st plaintiff about what had transpired. As he was doing so, the deceased was being reversed from general anaesthesia by the 2nd defendant. The notes indicate that this was around 7pm.

[10] During this reversal, the deceased went into cardiac arrest. The 1st defendant rushed to the operation theatre to assist the 2nd defendant. After about 20 minutes, the deceased was resuscitated. She regained spontaneous respiration and was stable. At this juncture, the 1st defendant made a presumptive diagnosis of cerebral ischemia - the cardiac arrest had resulted in an interruption of blood supply and thus oxygen to the deceased's brain. It was decided that she should be sent to GIMC for a brain scan investigation. Arrangements were made with Dr Valar Subramaniam, consultant radiologist and Dr Mohandas, consultant anaesthetist at GIMC for transfer of deceased to GIMC.

[11] The deceased was then transferred from Springvale to GIMC in an ambulance. The 2nd defendant and the paramedics were in attendance with the deceased during her transfer to GIMC.

[12] At GIMC, the deceased was placed in the intensive care unit ("ICU"). The intensivist was Dr Mohandas, the consultant anaesthetist. She was also managed and cared for by Dr Devan Pillay, consultant cardiologist, Dr Faridah Ismail, consultant endocrinologist and the 1st defendant.

[13] Dr Devan Pillay conducted an echocardiogram and found that the deceased's heart condition was good. Her left and right ventricles appeared good, there was no pericardial effusion, the cardiac chambers were not dilated and there was no evidence of pulmonary embolism. However, despite the care and treatment, the deceased suffered a cardiac arrest at around 7.42am on 23 June 2004. Attempts at resuscitation failed. She succumbed and died at 8.05am.

[14] A post-mortem was conducted on the same day at 2pm by Dr Hamidah bt Abdul Jalil, a forensic pathologist attached to the Forensic Department of Hospital Kuala Lumpur. She prepared a post-mortem report dated 4 August 2004. The material findings of the port-mortem report were as follows:

a. 100 mis of fluid blood was found in the abdominal cavity of the deceased;

b. The deceased's heart was reported to be normal;

c. There was no pulmonary embolism noted;

d. The deceased's liver showed linear imprint abrasions. A subcapsular haematoma of 1 cm in diameter was also noted over front aspect of right lobe of the liver.

e. The peritoneal layer over front of the right abdomen showed multiple small circular to oval shaped perforations ranging from 2 to 6 mm in average diameter. There were also multiple minute perforations in the mesentery of the large colon.

f. The cause of death was stated as "Acute intraabdominal injury (Perioperative death)".

The Law

[15] In relation to the plaintiffs' claim, the burden is on them to prove negligence on the part of the defendants on a balance of probabilities. In the instant case, there is no question that the defendants owed a duty and standard of care to the deceased. So the plaintiffs will have to prove that the defendants had breached this duty. The plaintiffs will also have to prove that it was this breach that caused the death of the deceased. This means that the plaintiffs must prove that it was the negligence of the defendants rather than some other factor which cause her death. In a nutshell, the burden was on the plaintiffs to prove breach of duty and causation on a balance of probabilities.

[16] Now of course there may be cases where a *prima facie* inference of negligence may arise from a consideration of all the surrounding circumstances by recourse to the maxim known as r*es ipsa loquitur*. Whether this maxim applies in the instant case will be dealt with later on in this judgment.

Breach Of Duty And Standard Of Care

[17] In relation to breach of duty and standard of care, it was submitted that the Bolam test still applies in Malaysia in respect of diagnosis and treatment but not to the giving of advice on material risks inherent in proposed treatments.

[18] To recall, the Bolam test was formulated as follows:

> A doctor is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular act .... Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. (per McNair J in *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118 at 122).

[19] The Federal Court in *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229 had occasion to consider the Bolam test. Siti Norma Yaakub FCJ (as she then was) in delivering the judgment of the court, stated as follows (at p 249):

> That said, we are of the opinion that the Bolam test has no relevance to the duty and standard of care of a medical practitioner **in providing advice to a patient** on the inherent and material risks of the proposed treatment. The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment (Emphasis added).

[20] In essence, the Federal Court rejected the *Bolam* test and instead preferred the test as adopted in *Rogers v. Whitaker* [1992] 175 CLR 479 which was a decision of the High Court of Australia.

[21] Whilst it may be correct to suggest that the Federal Court in *Foo Fio Na* was only dealing with the question of negligent advice, there are other reasons why the *Bolam* test as it has been applied in a large majority of cases may not also be the appropriate test in the realm of diagnosis and treatment of the patient.

[22] Firstly, there is a distinction between the test of negligence based on the reasonable competent man and that of the ordinary skilled man. The Federal Court in *Foo Fio Na* dealt with this distinction by reference to the views of Michael Jones in his book "Medical Negligence". This appears at p. 257 of the judgment as follows:

> Finally, we make reference to Michael Jones' book on Medical Negligence [1996] ed, p 95 that seems to suggest that there is a distinction between the test of negligence based on the reasonable competent man and that of the ordinary skilled man. The former makes it clear that negligence is concerned with the departures from what ought to have been done in the circumstances which is measured by reference to a hypothetical 'reasonable doctor' and the latter places considerable emphasis on the standards which are in fact adopted by the profession. He emphasizes that the point is for the court to determine what the reasonable doctor would have done, not the profession. What the profession does in a given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In the final analysis, the court should set the standard of care in negligence, drawing upon the evidence presented. The *Bolam* Test fails to make this important distinction between the reasonable competent doctor and the ordinary skilled doctor.

[23] This is consistent with the view expressed by Lord Browne - Wilkinson in *Bolitho (Administratix Of The Estate Of Bolitho (Deceased) v. City and Hackney Health Authority* [1997] 4 All ER 771 where he states as follows (at p. 778):

> My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In *Bolam*'s case [1957] 2 All ER 118 at 122, [1957] 1 WLR 583 at 587 McNair J stated that the defendant had to have acted in accordance with the practice accepted as proper by a '**responsible** body of medical men (my emphasis). Later he referred to a standard of practice recognized as proper by a competent reasonable body of opinion' (see [1957] 2 All ER 118 at 122, [1957] 1 WLR 583 at 588; my emphasis). Again, in the passage which I have cited from *Maynard*'s case, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives responsible, reasonable and respectable - all show that the court has to be satisfied that the exponents of the body of opinion relied on can demonstrate that such opinion has a logical basis. In particular, in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.

[24] Secondly, the Federal Court in *Foo Fio Na* held that the test that applied was the test in *Rogers v. Whitaker*, a decision of the High Court of Australia. The position in Australia has since evolved with the High Court decision in *Naxakis v. Western General*

Hospital & Another [1999] 162 ALR 540 where the Australian apex court accepted that the test in *Rogers v. Whitaker* applied also in the realm of diagnosis and treatment. Any resurrection of the *Bolam* principle was rejected. In England as well, the House of Lords in *Bolitho*, *supra*, considered the *Bolam* test in a new light. Lord Brown-Wilkinson, who delivered the judgment of the House of Lords, came to the following view (at p 779):

> These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied on is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

[25] At home, Low Hop Bing J (as he then was) in *Chien Tham Kong v. Excellent Strategy Sdn Bhd & Ors* [2008] 1 LNS 411 accepted that the test in *Foo Fio Na* applied in all areas of medical negligence. It would therefore appear that the *Bolam* test, where it requires the court to accept the views of medical experts even though the logical force of such opinions are unpersuasive, is now out of favour.

[26] On my part, I am also inclined to the view that the test of standard of care should be a matter of legal judgment as opposed to medical judgment. In my view, this is appropriate as the analysis of care and skill of medical practitioners should be no different to that employed in judging the acts of other professionals. An objective assessment of the standard of care is necessary so as to evaluate and monitor such professional standards. I would therefore hold that the correct approach is that stated in *Bolitho* in cases of diagnosis and treatment as adverted to earlier. I would add, with respect, that this approach is also not inconsistent with the reasoning in *Foo Fio Na*. In effect, the same test would now apply in all areas of medical negligence.

[27] I must hasten to add that medical practitioners should not be unduly worried with this state of affairs. In the case of diagnosis and treatment, the court would have to rely on expert opinion. Standards and practices generally accepted by distinguished members of the medical profession will normally be decisive. In *Bolitho*, Lord Browne Wilkinson reiterated (at p 779):

> I emphasise that, in my view, it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed.

Liability

[28] As observed earlier, liability will depend on whether there was first a breach of duty and standard of care and second, if it was the case that the defendants were negligent, whether it was their negligence that caused the deceased's death. For convenience and in view of the particular facts and circumstances in this case, I will take the two issues together.

[29] To prove their case, the plaintiffs appeared to rely entirely on the post-mortem report. However, the forensic pathologist Dr Hamidah bt Abdul Jalil, who conducted the post-mortem and prepared the report, was never called to give evidence. According to her superior, Dr Mohd Shah Mahmood (SP2), who was the Head of Department at the Department of Forensic Medicine in Hospital Kuala Lumpur, Dr Hamidah had not returned after completing a course she had attended in the United States. Effectively therefore, there was no independent expert medical opinion provided by the plaintiffs. Taking this position was, to my mind and with respect, imprudent and injudicious. The reason is this. Since the onus to prove causation was on the plaintiffs, expert medical opinion would have been vital to prove that it was the defendant's negligence that caused the demise of the deceased (see *Hong Chuan Lay v. Dr Eddie Soo Fook Mun* [1998] 5 CLJ 251 and *Payremalu Veerappan v. Dr Amarjeet Kaur & Ors* [2001] 4 CLJ 380).

[30] As for the post-mortem report, although Dr Hamidah was not present to give evidence, it was fortunate that all the parties were quite happy to rely on the contents of the post-mortem report. It was only the conclusion relating to the cause of death that was strenuously disputed. At first sight, the cause of death of acute intra-abdominal injury appeared to be damning of the 1st defendant. However, the evidence of the medical experts in the trial showed that this conclusion could not be sustained.

[31] On the question of cause of death, Dr Mohd Shah Mahmood (PW2) did not agree with the conclusion of Dr Hamidah in the post-mortem report. He was of the view that neither the amount of blood loss in the abdominal cavity nor the injuries reported could have caused death or likely to have caused a cardiac arrest.

[32] Dr Mohd Shah's view was supported by the other independent medical experts. Dato' Dr JC Mehta (DW5), an eminent general surgeon of many years' experience and with special interest in the liver was of the view that the injuries were minor and did not warrant any surgical intervention. He was also of the view that the blood loss was not substantial and disagreed with the conclusion given in the post-mortem report. In his view, the total amount of blood loss, which would not be more than 400 mls, would not cause cardiac arrest.

[33] Professor Malcolm Fisher (DW6), an eminent consultant physician and intensivist and clinical professor in the Department of Anaesthesia and the Department of Medicine at the University of Sydney, Australia, testified that he could not relate to the conclusion made in the post-mortem to the injuries described. He opined that only a sudden blood loss in excess of 1,500 mls or a slow continuing blood loss in excess of 3,000 mls would precipitate a cardiac arrest. He also described the injuries as very minor which would have healed in a short time. He said that injuries to the peritoneum were common and he was not aware that such injuries lead to adverse consequences. He was of the firm opinion that none of the complications encountered were potential surgical causes of cardiac arrest.

[34] Professor Emeritus Datuk Dr Alex Delikan (DW3), an eminent consultant anaesthetist and Professor Emeritus for Anaesthesiology & Critical Care, University Hospital, opined that blood loss was not the cause of the problems but rather the stimulation on the peritoneum that caused arrhythmic changes on the heart. This could have triggered cardiac arrest.

[35] However, he appeared to be relying on a different Anaesthetic & Observation Chart and not the one that the parties had accepted as the correct one. It transpired that there were two charts produced by the 1st defendant prior to the trial. The one referred to by Professor Datuk Delikan was the one included in the disputed bundle of documents. This was objected to by both the plaintiffs and the 2nd defendant. Much later during the trial, learned counsel for the plaintiffs had a change of heart and wanted the court to consider the second chart. Now this was highly unusual to say the least. This flip-flop stance, with respect, no doubt stemmed from the fact that the plaintiffs did not have the benefit, at the outset, of independent medical opinion.

[36] The main difference in the two charts was that in the second or disputed chart, the blood pressure recorded was elevated at 170/120 and 180/110 and a drug called labetelol was administered to the patient. This was a drug used for the control of elevated blood pressure. Apart from these differences, the nature of the treatments and the time they were afforded in both charts appeared strikingly similar. These particulars, except for the name of the deceased, were entered in the 2nd defendant's handwriting as he himself admitted. The 2nd defendant explained that the first chart was the correct one and the second chart was not that of the deceased. He further explained that the second page of the disputed chart referred to the deceased as he entered more details when he could do so after the incident. However, he denied that the first page of the disputed chart referred to her and he could not understand nor explain how the two pages were annexed together. He clarified that these documents were at all times kept in the custody of the 1st defendant's clinic. He denied that the deceased's blood pressure was elevated and that he had administered labetelol.

[37] That this was going to be the stand of the 2nd defendant should not have surprised anyone. I would have thought that the plaintiffs would have been appraised by medical experts on the significance of the differences in the two charts and having done so come to the position that they would settle for the first chart. If the plaintiffs had any misgivings about the charts, they would surely have resorted to discovery or interrogatories to determine the true position. Instead, they appeared to be happy with the first chart as it appeared in the agreed bundle with the second chart in the disputed bundle. Furthermore, I noted that the second chart was scanned from a document and then saved onto the computer in the 1st defendant's clinic. The original was never produced and no evidence was elicited as to what happened to it. In the face of the

2nd defendant's denial, it would have been unsafe to rely on the second chart. For these reasons, I had no option but to accept the first chart to be the correct chart as was the stance adopted by the parties prior to the trial.

[38] Now if Professor Datuk Delikan was looking at the wrong chart, then his hypothesis cannot be right. To be fair, this is no fault of his. He was provided with the second chart by the 2nd defendant since it was also disclosed but he really ought to have been apprised of the situation. I say the hypothesis cannot be right because the correct chart shows that the vital signs and heart beat of the deceased were normal throughout the liposuction procedure. Furthermore and more importantly, it was the opinion of Professor Fisher, which was supported by Dato' Dr JC Mehta, that the peritoneum does not produce a systemic response when cut, handled or pricked. He further opined that any cardiovascular response, if any, would have been immediate and would not produce a delayed cardiac arrest. For these reasons, I think with respect, Professor Datuk Delikan's hypothesis in this regard ought to be discounted.

[39] As for the drug labetelol, Professor Datuk Delikan explained that it would be used when the blood pressure was labile (fluctuating) to steady things. Professor Fisher noted that the drug was a beta blocker and if used it would have made the resuscitation difficult. It is however noteworthy that both Professor Datuk Delikan and Professor Fisher were of the view that the administration of general anaesthesia, resuscitation and the transfer of the deceased to GIMC could not be faulted.

[40] Now that being the sum total of the evidence, the cause of death as stated in the post-mortem report cannot be right. The evidence as I have accepted it shows that neither the blood loss nor the injuries in the abdominal cavity caused the cardiac arrest or death of the deceased. The post-mortem report also does not make reference to any anaesthetic problems or complications. It would therefore appear to me that the plaintiffs have failed to prove any negligence on the part of the defendants.

[41] So what caused her death? Fortunately, there is another and I think more compelling hypothesis for the cardiac arrest. This was proffered by Professor Fisher. He said that the cardiac arrest could be from a reaction to the anesthetic drugs used. He particularly mentioned the drugs Atrophine and Neostigmine which were used for the reversal of the general anaesthesia. According to Professor Fisher, it was significant that the cardiac arrest occurred during

reversal as any reaction to such drugs would be immediate. He also opined that this was supported by the 1st plaintiff's observation that soon after the procedure, the deceased was puffy and swollen around her eyes which would indicate an allergic reaction.

[42] Nevertheless, he was very clear that these drugs are routinely and properly given by anaesthetists. To suffer an anaphylactic shock from these drugs was a rare condition. So the giving of these drugs could not have been negligent in any way. To stress the point, he said that it would be negligence if the said drugs were not given as there was no substitute for them for the reversal process.

[43] In considering possible negligence, I have also not overlooked the long list of particulars of negligence and breach of duty as set out in the statement of claim. They range from failing to equip the clinic with the necessary facilities, to its improper design, to the improper transfer of the deceased and to the failure of the defendants to exercise reasonable care and skill. None of these criticisms have been demonstrated to be valid by any relevant or credible evidence, medical or otherwise.

The Causation Element

[44] The plaintiffs also appear to contend that the principle of causation is satisfied by the idea that the deceased would not have died if she had not undergone the liposuction procedure and therefore her death must be due to the negligence in her management. With respect, this idea is overly simplistic and myopic and is misconceived for the following reasons. As I have said elsewhere, our system of justice requires proof according to the rules of evidence and not conjecture. It may sometimes appear harsh that the hurdle of causation leaves a patient uncompensated. However, it may well be the case where that injury or death could be due to several potential causes and it would be unfair to impose liability on a medical practitioner if the cause of injury or death is not attributable to him or her.

[45] In *Wilsher v. Essex Area Health Authority* [1988] 1 All ER 871, the infant plaintiff who was born prematurely was given excess oxygen. The infant developed retrolental fibroplasia which resulted in blindness. This retinal condition could have been caused by excess oxygen but it also occurred in premature babies. On appeal it was held by the House of Lords as follows:

> Where a plaintiff's injury was attributable to a number of causes, one of which was the defendant's negligence, the combination of the defendant's breach of duty and the plaintiff's injury did not give rise to a presumption that the defendant had caused the injury. Instead the

A burden remained on the plaintiff to prove the causative link between the defendant's negligence and his injury, although that link could legitimately be inferred from the evidence. Since the plaintiff's retinal condition could have been caused by any number of different agents and it had not been proved that it was caused by the failure to prevent excess oxygen being given to him the plaintiff had not discharged the B burden of proof as to causation.

[46] Another example is where the injury or death would have occurred in any event. In *Barnet v. Chelsea & Kensington Hospital Management Committee* [1968] 1 All ER 1068, three night watchmen C went to the casualty department of the defendant's hospital. They complained of vomiting after drinking some tea. The doctor at the casualty department told them to go home without examining them. They went away but some hours later, one of them died from what was found to be arsenical poisoning. There was evidence that since arsenical poisoning was rare, even if the deceased had been D examined and admitted to hospital and treated, there was little or no chance that the only effective antidote would have been administered to him before the time at which he died.

[47] It was held that although the hospital casualty doctor was E negligent in failing to see and examine the deceased, it was not proven on a balance of probabilities that it was the defendants' negligence which caused the patient's death and the claim was dismissed.

[48] The difficulty, of course, arises where, because of the F limitations or uncertainties of scientific knowledge in the sphere of medical liability, the cause of the injury or death remains a mystery. How should the courts look at such cases? I think we should accept that although much progress has been made in the field of medicine, there is yet a lot that we do not know. In *Roe v. Minister* G *of Health* [1954] 2 QB 66, Lord Denning observed (at p 83):

> Medical science has conferred great benefits on mankind, but these benefits are attended by risks. ... We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience H often teaches in a hard way.

[49] I think that observation remains relevant today. So until today, all surgeries do carry risks. Medical mishaps will occur. No medical doctor can guarantee a mishap free procedure or that there I would not be any possible adverse consequences. This is precisely why when a mishap occurs, it does not automatically follow that it was due to negligence. The plaintiff will have to prove that what was done was what a reasonably competent practitioner skilled in

that particular art would not have done or done, as the case maybe. Even if it was proven that there was negligence, it must be further proven that it was such negligence which caused the damage for which the plaintiff is claiming compensation.

Reopening Plaintiffs' Case

[50] Coming back to the instant case, I would have thought the plaintiffs had understood the importance of proving the causation element when they applied to reopen the plaintiff's case by calling Dr Mohandas, a consultant anaesthetist at GIMC. Now this was an unusual request. The plaintiffs had closed their case. The defendants were far into their case. The reason given was that there was some suggestion by the witnesses for the defendants that the deceased may have been mismanaged at GIMC. Learned counsel for the plaintiffs submitted that she had to call this witness to rebut those allegations.

[51] The law governing the reopening of a party's case was appraised by the Court of Appeal in *Tan Kah Khiam v. Liew Chin Chuan & Anor* [2006] 4 CLJ 715. It was held by the court that such exercise of discretion depended very much as to where the justice of the case lies having regard to the peculiar facts and circumstances before the court. Gopal Sri Ram JCA (as he then was) in delivering the judgment of the court referred with approval to the decision in *TD Canada Trust v. McMaster et al* [2003] BCD (Civ) 16394, where Garson J said:

> In *Dudas v. Munroe* [1993] BCJ 2035 (SC) (QL), Braidwood J (as he then was) summarized the law concerning the court's discretion to re-open a trial before judgment is entered as follows:
>
> > In deciding whether or not to re-open a case, the governing considerations are first, would a miscarriage of justice probably occur without a re-hearing; and second, would a re-hearing probably produce a change of result? The discretion to re-open a trial before judgment is entered is an unfettered discretion but one that should be used sparingly (*Sykes v. Sykes* [1995] 6 BCLR (3d) 296 (CA) and has as its purpose the correction of what would otherwise be a miscarriage of justice (*Kemp v. Wittenberg*, [1999] BCJ 810 (SC)).

[52] To this should be added another consideration which is that the other party should suffer no prejudice or injustice (see *Tan Kan Khiam v. Liew Chin Chuan & Anor*, *supra* at 456 and *Ong Yoke Eng & Anor v. Lim Ah Yew* [1981] 1 LNS 162; [1982] 1 MLJ 226 at 227).

[53] In the instant case, the application was allowed as the cause of death of the deceased was the pivotal issue to be decided at the end of the trial and notwithstanding the lack of diligence on the part of learned counsel for the plaintiffs in anticipating this issue and the strenuous objections put forward by the defendants, I considered it fair and just that they be allowed to reopen their case. In doing so, I was very much influenced by the fact that the witness, Dr Mohandas, was willing and able to be present during the time that was set for the trial. This was a decisive factor as the defendants' experts were still available and could be recalled to give further evidence once the new witness had completed his testimony.

[54] However, it later transpired that the witness was not so willing to give evidence after all - probably constrained by legal advice. He was also not able to do so, contrary to what learned counsel for the plaintiffs had earlier told the court, as he had to attend to surgeries scheduled for the day. This prompted learned counsel for the plaintiffs to apply for an adjournment which of course had to be refused. The reason would have been obvious. The reopening of the case was allowed on the understanding, as was indicated to the court by learned counsel for the plaintiffs, that the witness was willing and able to come on the trial dates fixed even without a subpoena. This, as we know, turned out to be miles removed from what transpired eventually. An adjournment would also prejudice the defendants as they had obtained the services of their experts with great difficulty. They had come prepared with an expert witness who came to testify whilst still in a wheelchair soon after spinal surgery; another expert witness who arrived from Australia and had to leave immediately after the trial to attend to his busy schedule and yet another expert who had to be prised away from his teaching commitments to attend court. I do not think, with respect, it was now open to learned counsel for the plaintiffs to complain and seek an adjournment. After having been given an opportunity to reopen the case, it would be unjust now to adjourn the trial as that would very much seem like the plaintiffs were taking advantage of a situation of which they were the authors in the first place. It would also prejudice the defendants as they would be put to great difficulty and expense to recall their own witnesses.

[55] In any event and significantly so as it turned out, no submission was made at the end of the trial by either defendant that GIMC had somehow mismanaged the deceased. It was common ground that Dr Mohandas was to appear as a witness of fact and not as an expert. Since it now appeared that there was no issue as to whether there was any mismanagement at GIMC

affecting the causation element, Dr Mohandas' testimony is rendered irrelevant. This is of course with the benefit of hindsight. I might also add, with the same hindsight, that perhaps the application to reopen the case ought not to have been allowed.

Res Ipsa Loquitur

[56] I come back to the question of whether in the circumstances, the maxim *res ipsa loquitur* applies. This doctrine is not a rule of law but essentially a rule of evidence and common sense. If the circumstances of the case suggest that the maxim applies, a *prima facie* inference of negligence is then drawn.

[57] The principle was first explained in *Scoft v. London & St Katharine Docks Co* [1865] 3 H & C 596 by Erie CJ as follows (at p 667):

> There must be some reasonable evidence of negligence. But where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, if affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.

[58] In *Lloyde v. West Midlands Gas Board* [1971] 2 All ER 1240, Megaw LJ described the rule in the following terms (at p 1246):

> It means that a plaintiff *prima facie* established negligence where:
>
> (i) it is not possible for him to prove precisely what was the relevant act or omission which set in train the event leading to the accident, but
>
> (ii) on the evidence as it stands at the relevant time it is more likely than not that the effective cause of the accident was some act or omission of the defendant or of someone for whom the defendant was responsible, which act or omission constitutes a failure to take proper care for the plaintiff's safety.

[59] What is central to the doctrine is that there must exist a situation or circumstance such that one can safely conclude that in the ordinary cause of things, the event under investigation would not have occurred without any negligence or fault on the part of the defendant.

[60] In the field of medicine, however, there are very few instances where this doctrine may apply. This is because the human body and medical treatment are not amenable to logical deduction unlike man made machines or things mechanical which have parameters which are clearly known and understood. There are far too many variables

and as I have said before, medical treatment is not quite a precise science. The human body itself is subject to many unexplained mysteries. Only in clear cases such as swabs left in the abdomen after surgery (*Mahon v. Osborne* [1939] 2 KB 14), would there be an exception.

[61] In *Girard v. Royal Columbian Hospital et al* 66 DLR (3d) 676, Andrews J of the British Columbia Supreme Court held (at the headnotes):

> The human body is not a container filled with a material whose performance can be predictably charted and analysed. It cannot be equated with a box of chewing tobacco or a soft drink. Thus, while permissible inferences may be drawn as to the normal behaviour of these types of commodities the same kind of reasoning does not necessarily apply to a human being. Because of this, medical science has not yet reached the stage where the law ought to presume that a patient must come out of an operation as well as or better than he went into it. The medical evidence indicated that the kind of injury suffered by the plaintiff could have occurred without negligence on anyone's part. Hence the maxim *res ipsa loquitur* did not apply.

[62] For the same reason, Raja Azlan Shah J (as His Royal Highness then was) in *Elizabeth Choo v. Government of Malaysia* & *Anor* [1960] 1 LNS 24; [1970] 2 MLJ 171 observed (at p 172):

> Mr. Peddle claimed to be able to invoke the doctrine of *res ipsa loquitur* on the basis that the anaesthetist had failed to avoid perforating the intestine which he ought to have done. He seemed to take the view that the occurrence spoke of negligence on the part of anaesthetist. In my judgment the doctrine could not be invoked by the plaintiff. There could be no presumption of negligence arising from the mere circumstance that the anaesthetist failed to avoid perforation because that might have been caused by causes beyond his control. Liability must depend on the plaintiff establishing that there had been a want of competent care and skill.

[63] And more recently in *Foong Yeen Keng v. Assunta Hospital (M) Sdn Bhd & Anor* [2006] 1 CLJ 608, Raus J (as he then was) expressed the following view (at p 629):

> I am of the view that the maxim of *res ipsa loquitor* does not apply in this case. To me, the fact that the patient came out of a hospital in a worse condition before admittance does not constitute proof of negligence by the hospital staff. One must be able to accept that medical treatment carries the risk and the occurrence of injury is not necessarily evidence of lack of reasonable care.

[64] In the instant case, even if the injuries were caused by the 1st defendant as reported in the post-mortem report, it does not necessarily follow that he was negligent. The same applies with the 2nd defendant. There could certainly be other causes beyond their control. My assessment of the medical evidence suggests that the demise of the deceased could have resulted without negligence on anyone's part. It would therefore be inappropriate to infer negligence. So for these reasons, I do not think *res ipsa loquitur* applies.

[65] Even if the doctrine did apply, the defendants have gone to great lengths to discharge the evidential burden of demonstrating that their patient's demise was not caused or contributed by their acts or omissions through the testimony of their medical experts.

[66] In the circumstances, and for the reasons I have stated, I find that the plaintiffs have failed on a balance of probabilities to prove negligence on the part of the defendants. In the result and with much regret, the plaintiff's claim is dismissed with costs. After hearing the parties, and in view of the difficult circumstances prevailing in this case, I assessed costs on a discounted basis at RM20,000 for each defendant.